Initial Approval Date: April 10, 2019

CRITERIA FOR PRIOR AUTHORIZATION

Interleukin-5 (IL-5) Receptor Antagonist Agents

PROVIDER GROUP Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Reslizumab (Cinqair®)
Mepolizumab (Nucala®)
Benralizumab (Fasenra™)

For all agents listed above, the preferred PDL drug, if applicable, which covers that specific indication, is required unless the patient has a documented clinical rationale for using the non-preferred agent, which is supported by the label.

CRITERIA FOR INITIAL PRIOR AUTHORIZATION FOR ASTHMA: (must meet all of the following)

- Patient must have a diagnosis of severe asthma
- Must be prescribed by or in consultation with a pulmonologist, allergist, or immunologist
- Patient must be taking and be compliant with a high-dose inhaled corticosteroid (ICS) and a long-acting $beta_2$-agonist (LABA)
- The medication must be administered by a healthcare professional
- Patient must be of FDA approved age for use (listed below):
    - benralizumab (Fasenra™): ≥ 12 years of age
    - mepolizumab (Nucala®): ≥ 12 years of age
    - reslizumab (Cinqair®): ≥ 18 years of age
- Patient must have blood eosinophils of greater than or equal to 150 cells/mcL at baseline
- Patient must not be prescribed dual therapy with another monoclonal antibody for the treatment of asthma
- Medication must not exceed FDA approved dosing:
    - benralizumab (Fasenra™): 30 mg subcutaneously every 4 weeks for the first 3 doses, and then once every 8 weeks
    - mepolizumab (Nucala®): 100 mg subcutaneously once every 4 weeks
    - reslizumab (Cinqair®): 3 mg/kg IV once every 4 weeks

CRITERIA FOR RENEWAL PRIOR AUTHORIZATION FOR ASTHMA: (must meet all of the following)

- Patient must demonstrate a decrease in frequency of exacerbations from baseline (defined as a reduction of oral/systemic corticosteroids and/or hospitalization and/or emergency department visits)
- Patient must not be prescribed dual therapy with another monoclonal antibody for the treatment of asthma
- Medication must not exceed FDA approved dosing:
    - benralizumab (Fasenra™): 30 mg subcutaneously every 4 weeks for the first 3 doses, and then once every 8 weeks
    - mepolizumab (Nucala®): 100 mg subcutaneously once every 4 weeks
    - reslizumab (Cinqair®): 3 mg/kg IV once every 4 weeks

LENGTH OF APPROVAL (INITIAL AND RENEWAL): 12 months

INITIAL AND RENEWAL CRITERIA FOR EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA) (must meet all of the following)

- Request must be for mepolizumab (Nucala®)
- Must be prescribed by or in consultation with an allergist, immunologist, rheumatologist, or pulmonologist
- Patient must have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA; Churg-Strauss syndrome)
- Patient must be ≥ 18 years of age
- Patient must be symptomatic despite treatment with prior oral corticosteroids
- Dosing must not exceed 300 mg every 4 weeks

LENGTH OF APPROVAL (INITIAL AND RENEWAL): 12 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR	PHARMACY PROGRAM MANAGER DIVISION OF HEALTH CARE FINANCE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
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DATE	DATE